The influence of masculinity on HIVST community intervention: a qualitative evaluation of empirical evidence from Blantyre, Malawi

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Introduction

Sub-Sahara Africa (SSA) is disproportionately burdened by undiagnosed HIV; 70% of all new HIV infections occur in this region (UNAIDS, 2013).

HIV transmission is high in couples (Chemaitelly, 2014) and having an HIV test together as sexual partners and the disclosure of HIV–positive status is challenging in this group.

For HIV, population surveys and cohort outcomes show men to have a higher risk of undiagnosed disease than women, and higher risk of death following diagnosis (UNAIDS, 2014).

HIV self-testing (HIVST) has greater potential for scaling up testing to reach the under-served groups of people, including men (Napierala Mavedzenge et al., 2013).

It is established in literature that HIVST addresses barriers associated with traditional models of providing HIV testing, giving notably high male participation (Choko et al., 2015).

Here we report findings from an HIVST study with relevance to other chronic conditions, including TB.

Objectives

Here, we analysed the role of masculinity on HIVST decisions and subsequent actions amongst couples in urban Blantyre.

Methods

Study design

Sub-analysis of data within a 17 months qualitative cohort study exploring the long-term consequences of semi-supervised HIVST within couples on partnership dynamics and on linkage to care.

The qualitative study was nested within a cluster randomized trial (CRT) investigating the impact of intensified HIV/TB prevention on the incidence of bacteriologically confirmed TB in Blantyre

Analysed longitudinal data from study participants who:

. were >3 months in relationships
. self-tested as individuals
. self-tested tested as couples

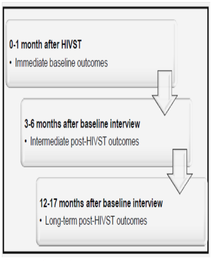

Figure 1: Data collection schema

Data collection

Conducted serial in-depth interviews (S-IDIs) and focus group discussions (FGDs) in Chichewa - a local language

Digital voice recorders were used to capture qualitative data

Data management and analysis

Verbatim transcription of data and NVIVO 9 QRS software used to organise and manage data

Mixed content and thematic analysis approaches used to analyse data using a modified ecological model:

a) Thematic data coding into meaningful analytical segments
b) Chronological sequencing of S-IDI data to detect change over time
c) Theoretical propositions – analytical framework (Figure 2)

Triangulation of data sources and data collected at different stages to enhance validity and reliability

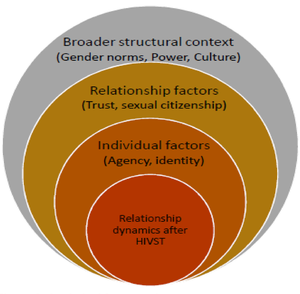

Figure 2: Analytical framework

Results

Demographic characteristics of participants

A total of 110 participants (Female n= 57) were included in this analysis (see Table 1).

Male participants were older, better educated and better engaged in gainful economic activities than female participants.

Table 1: Demographic characteristics of S-IDI and FGD study participants

Categories		Gender			
		Male		Female	
		S-IDI	FGDs	S-IDI	FGDs
		30	23	37	20
Age	Range	20-62	21-66	18-42	19-45
	Average	34	37	29	29
Education	No education	0.0%	0.0%	5.4%	0.0%
	Primary	40.0%	52.2%	51.4%	75.0%
	Secondary	53.3%	39.1%	40.5%	25.0%
	Tertiary	6.7%	8.7%	2.7%	0.0%
Occupation	Unemployed	0.0%	4.3%	75.7%	55.0%
	Informal	80.0%	82.7%	8.1%	40.0%
	Formal	20.0%	13.0%	16.2%	5.5%

Purposive recruitment of study participants (see Table 2)

. 67 Serial IDIs with self-testers including 7 HIV-discordant couple pairs (i.e. 4 couples where a female partner was HIV positive)
. 5 FGDs with community members

Table 2: Purposive sampling framework of S-IDI participants

Category	Sex	HIV status	Baseline	3 months	12 months
Individuals who self-tested with a partner	**Male**	HIV-positive	5	4	5
		HIV-negative	5	4	4
		HIV-discordant	7(4 HIV+)	6 (3 HIV+)	6 (3 HIV+)
	Female	HIV-positive	5	5	5
		HIV-negative	5	5	4
		HIV-discordant	7 (3 HIV+)	5 (3 HIV+)	5 (2 HIV+)
Individuals who self-tested as individuals	**Male**	HIV-positive, partner positive	4	3	3
		HIV-negative, partner negative	5	4	4
		HIV-positive or negative naive of partner status	4	2	3
	Female	HIV-positive, partner positive	7	3	3
		HIV-negative, partner negative	7	4	5
		HIV-positive or negative naive of partner status	6	4	3
TOTAL			**67**	**49**	**50**

Masculinity and HIVST

HIVST was considered to be attractive and convenient to men, removed some 'testing barriers' for men:

> *"These things [HIV testing] are frightening... that you should go there [facility], and stand in the queue. If my wife had told me to go to a hospital to test, I would have refused..."*(Male, HIV-positive, Discordant)

The mandate of constant economic provision prevented men living a hand-to-mouth existence from testing with their partners, as they were not at home when HIVST was offered:

> *"… he was at work… I self-tested alone because it is me who has this body and it is me who feels the pain. Because of this, they say 'a bag of life is cared by oneself'."* (Female, HIV-positive, Concordant)

Post-test risk-taking

Men took unnecessary risks irrespective of sero-status of themselves or their partner:

> *"I do not want that [condoms]… if I proposed you, if you accepted, it means I have to sleep with you without any problem [without being restricted to use condoms]."* (Male, HIV-positive, Discordant)

> *"…I can say that we do not use condoms each time we have sex because I am a person. I sometimes make mistakes of not using condoms."* (Male, HIV-positive, Discordant)

HIV-negative men unwilling to seek prevention irrespective of partners status:

> *"For me, good health is the one that is making me to do that [failing to have a repeat HIV test] because right now I have never been sick and good health is the one that is making me brave not to go to the hospital."* (Male, HIV-negative, Discordant)

The need to have biological children encouraged men to insist unprotected sex irrespective of own or partner's HIV sero-status:

> *"He complains to me that he cannot manage to be using [condoms] until death do us part because I have not yet given him a child."* (Female, HIV-negative, Discordant)

Post-test behavior after discordant results

For those in HIV discordant relationship, men remain in denial irrespective of test result:

> *"I see that he thinks a lot these days. When I speak to him, it seems as if he is not concerned. In the past, he used to tell me many things that he had encountered and we used to laugh, but now. He just stays quiet."* (Female, HIV-positive, HIV-discordant)

Notions of men as all-knowing could promote denial of positive HIVST results, with men allowed to question their authenticity especially when their partner had tested negative:

> *"I failed to understand how this was possible [that test results were discordant]. I sometimes ask myself that possibly its these sachets [locally distilled rum] that constantly burst [breaks and drink] that have burnt [killed] the virus inside my body?"* (Male, HIV-negative, Discordant)

HIV negative men are more likely to abandon their infected partners because of their inability to cope with traumatic self-test results:

> *"When she went to her village, I told her that, 'please do not come back [to the matrimonial home], your friend [a second wife] has come.'…since then she never came back."* (Man, HIV-negative, Discordant)

Men and health seeking behaviour

HIV-positive very slow to access HIV care - notions of strength and resilience, combined with the relentless demands of their household provider role, dissuaded men from promptly seeking HIV care, as they felt no urgency to act when healthy:

> *"... what I fear in my life is to take medication...that thing alone. ... it would make 'busy' to be taking medication daily, that every day I should be taking medication...I do not take medication often because I do not get seriously ill for four days or five days, no. When I am sick today, I will be working tomorrow. I usually work even when I am sick"* (Male, HIV-positive, Concordant)

Discussion and conclusions

To attain the 90-90-90 targets, the flexibility and convenience offered by HIVST makes self-testing a better option for reaching men who are usually neglected by the routine HIV testing approaches.

However, the conception of masculinity dictates men's post-test actions and behaviour such as having control over own health and life style, strength and toughness despite HIV infection, and display of sexual potency and economic productivity.

Masculinity, which includes relentless pressure to earn in this impoverished urban setting, restricted the potential benefits of early HIV care and prevention, amongst men.

Community HIV strategies need to explicitly account for the obstacles and barriers linked to masculinity to have full impact.

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